Definitions of Terms

- **ADVISORY BODY**
  A method that seeks guidance and counsel from community representatives, health care administrators and professionals, regarding diabetes educational, clinical and public health programs within the community.

- **ANNUAL PLAN/PROGRAM PLAN**
  Documentation that describes yearly program goals, objectives, implementation process and methods, resource requirements/budget, consumer access and evaluation methods. Diabetes team uses the annual plan to monitor activities and outcomes.

- **BEHAVIORAL OBJECTIVE**
  Medical record documentation of a patient identified behavior that he/she is willing to change. The individual behavioral objective should be realistic and measurable.

- **CEU**
  Continuing Education Unit, documented in hours of continuing education activity. Includes CEU from accredited organizations and certificates of attendance at diabetes related in-services, regional meetings, etc. It is expected that professional staff will document a majority of accredited CEU. Paraprofessional staff may have a greater mix of accredited and non-accredited CEU.

- **COMMUNITY**
  The social, cultural, political and geographic environment within which the Indian health facility offers services.

- **CONSISTENT**
  Diabetes team members use the same terms, materials and descriptors when educating the community, individuals, or families; "everyone is getting the same message."

- **CONSUMER ACCESS**
  A policy and process used to instruct providers, individuals and families about how to receive educational, clinical, or public health services.

- **COORDINATED**
  Diabetes team works together in program planning, implementation and evaluation.

- **EDUCATIONAL PLAN**
  Documentation of an individual's learning and behavioral objectives, intervention and follow-up, based on their educational needs assessment.

- **GOAL**
  A statement that defines the program's aim or purpose.

- **IHS DIABETES CARE AND OUTCOMES AUDIT**
  A diabetes care surveillance system that tracks performance on more than 87 indicators to study trends over time. The system is based on *IHS Standards of Diabetes Care* updated every two years.

- **IHS RECOGNIZED PROGRAM**
  A quality diabetes education program operating within American Indian or Alaska Native communities that meets the *National Standards for Diabetes Self-Management Education*.

- **INSTRUCTIONAL MATERIAL**
  Any material used in educational programming including pamphlets, audio-visuals, models, etc.

- **INDIVIDUALIZED EDUCATIONAL ASSESSMENT**
  The process used to identify learning needs with an individual; includes relevant medical history, diabetes history, risk factors, cultural influences, health beliefs and attitudes, barriers to learning, health behavior goals, support systems and other socioeconomic factors. Most information should be gathered during an interactive interview with the instructor.

- **INTEGRATED PUBLIC HEALTH APPROACH**
  Indian health diabetes program that offers quality diabetes education, clinical and public health services to consumers.

- **LEARNING OBJECTIVE**
  A statement that defines an individual's educational aim and purpose based on individual assessment.

- **PERIODIC ASSESSMENT**
  A set time period for evaluation of learning or behavioral objectives and/or follow-up plan.

- **PROGRAM MANUAL**
  Documentation that describes policies, procedures and other facility systems created to enhance diabetes education, clinical care and public health services within the community.

- **PROGRAM OBJECTIVE**
  A statement that defines a program's aim and purpose based on program goals.

- **RESOURCES**
  Space, materials, staff, training, technical support, budget, etc. available in a community to enhance, support or assist diabetes self-management.

- **STAKEHOLDERS**
  Community members, individuals and families eligible for diabetes education, clinical and/or public health services.

- **SURVEILLANCE**
  Data obtained within a set time period (weekly, quarterly, annually, etc.)

- **TARGET POPULATION**
  The group of individuals and families who have the characteristics that the diabetes program defines as program participants, such as new diagnosis, elders, youth, people with neuropathy, etc.